

REPLACEMENT EXHIBIT B

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House Education and the Workforce Committee Holds Hearing on the Health and Human Services Department's Policies and Priorities

LIST OF PANEL MEMBERS AND WITNESSES

KLINE:

A quorum being present, the committee will come to order. Well, good morning, everybody. Good morning, Madam Secretary. Welcome. We are delighted that you're here. I believe this is your first appearance before the committee, and we certainly appreciate the opportunity to meet with you today.

I realize your time is valuable and we only have a small window to discuss a wide range of topics. And as we discussed earlier, it is likely that we will be interrupted by votes pretty quickly, so administrative comment for all my colleagues -- Mr. Miller and I and the secretary are going to all try to get our opening statements done, and at least Mr. Miller and I, depending upon (inaudible) votes.

By any definition, the Department of Health and Human Services is a massive federal agency. It employs nearly 76,000 workers and maintains an annual operating budget in excess of \$800 billion, the largest of any agency in the federal government.

While a great deal of the department's resources are directed to Medicare and Medicaid, more than \$100 billion in taxpayer money is spent on various social service programs. Many of these programs fall within the jurisdiction of this committee, such as welfare, the Community Services Block Grant and provisions of the Child Abuse Prevention and Treatment Act.

No doubt, these programs are well intended. They reflect our nation's ongoing commitment to serving those in need. In recent years, however, the federal budget has been placed on an unsustainable path taxpayers can no longer afford. This growth has forced us to take a hard look at every facet of the federal government as we consider how to rein in spending.

I realize administration has offered some modest proposals for scaling back the cost of your department, Madam Secretary. However, these proposals fail to rise to the challenges we face.

If we adopt the president's plan, the Congressional budget office reports that federal government will spend \$46.2 trillion and pose \$1.5 trillion in new taxes and add roughly \$9 trillion to the national debt over the next decade. This is unacceptable. In health care, the news is just as disappointing.

It has been a little more than a year since the president signed his healthcare bill into law, yet already the price tag for the new law has increased by more than 50 percent. A plan that supported promise that would have reduced costs, well instead charge taxpayers more than \$2.6 trillion when fully implemented and add more than \$700 billion to the deficit.

Our national conversation has become so consumed by trillions and billions that it's almost impossible to comprehend the magnitude of the crisis we face. These reckless policies affect not only the nation's bottom line; they undermine confidence in our economy and harm job creators' ability to expand businesses or hire new workers.

The current fiscal crisis demands that we examine every program to ensure every taxpayer dollar is spent efficiently and effectively. Every federal agency must be part of that effort. If we fail to promote responsible reforms and make tough choices, our nation will no longer be able to provide assistance to those who need it most.

Those who argue for a tender response threaten the very safety net many Americans rely upon. We know many of the decisions that we must make will be unpopular. Writing about the spending cuts and the Final Appropriations Bill, the president's communications director noted quote, "Many will be painful and are to programs that we support, but the fiscal situation is such that we have to act," close quote, and I couldn't agree more.

The nation faces a historic moment. We can continue the status quo of more spending, more taxes and more debt that will ultimately lead to our nation's decline, or we can make the tough yet necessary choices to reserve the promise of our country and the prosperity of our children.

That's the cause the majority of this house has supported and one that I believe an overwhelming majority of the American people expect us to take.

This time I'd like to recognize Mr. Miller, the senior Democratic member of the committee for his opening remarks.

MILLER:

Thank you, Mr. Chairman and thank you for having us here. And I want to join you in welcoming Secretary Sebelius to the committee. From educating our youngest children in Head Start to ensuring seniors access to health care and Medicare, your department administers programs that have unquestionably made our communities and families healthier and our country stronger.

In recent months, we've seen an unprecedented attack on these programs that help millions of American families. While we must address our nation's long-term deficits, the budget priorities pursued by the Republican majority have put much of the sacrifice directly on the backs of children and seniors.

Cutting 130,000 children from Head Start isn't about rebuilding our economy. The repealing of the historic health care reform law won't help families and businesses get costs under control. You and your agency, Madam Secretary, have primary responsibility for implementation of the Affordable Care Act.

A year after its enactment, the reformed bill is still doing the right thing. It is the right thing to do to help families struggling with affordable coverage; it is the right thing to do for businesses crushed by skyrocketing premiums over the last decade and it was the right thing to do to finally end the worst abuses of the insurance industries.

The Affordable Care Act also makes significant strides in combating fraud and abuse in the Medicare and Medicaid system. And it includes key health care cost controllers, identified by top experts as critical to getting costs under control without rationing care.

And this is part of keeping the bargain, the bargain and the promise that this country made to our nation's seniors. It's a promise and a bargain that this nation must keep to our seniors.

However, the same cannot be said about the Republicans' budget. They achieved savings not by making Medicare work better but by shifting costs on to seniors. In fact, on the report we released this morning, seniors would have to shoulder approximately \$6,400 more in health care cost in 2022. The typical 65-year-old in 2022 will spend half of their Social Security on health insurance premiums under the Republican budget plan. And that cost increases with each passing year.

Using the CBO numbers, the Center on Economic Policy Research has found that to buy Medicare equivalent policy under the Republican plan, the median 85-year-old in 2050 would have to spend twice their annual income.

In this committee, we should be concerned about what this means for workers today. Based upon further analysis by the center, which I submit for the record, the 54-year-old today would have to save an additional, an additional \$182,000 over the next 11 years, just to pay for the increased health care cost under the Republican budget.

This is over and above what they're already putting away every month in their savings and their 401(k)s and their retirement plans. So these workers will have to find around an extra \$1,000 to \$1,300 a month to put in their IRAs or their 401(k) plan. And that is contingent upon the market not crashing right before they retire.

This committee has been concerned for years about the sufficiency of workers' retirement plans. In 2007, before the recent crisis, the Census Bureau found that half of all the workers had no retirement savings. In 2010, the Employee Benefits Research Institute found that the average retirement savings shortfall was over \$47,000 per individual, and all of that was counting on Medicare.

So how do these workers find another \$182,000, especially since for middle-class workers in this country, wages have essentially been stagnant since the 1970s. And labor protections for workers who try to organize and do better on the job for their families and for their communities, those abilities to organize are now under attack.

Under the Republican plan, seniors will go into debt. They will be forced to sell their homes that they've spent a lifetime paying off, and they'll have to rely on the children just to pay basic medical care.

This is not what anyone envisioned as a dignified retirement. This was not the bargain. This was not the promise that this nation made with its seniors. And I'd say that clearly understanding the need for additional reforms to make sure that Medicare is sustainable for seniors in the future and sustainable for taxpayers.

I'm very encouraged to see that as the Republican negotiators go to the White House today, they are reconsidering the idea that they would split Medicare; that they would put the 65-year-old in the

jeopardy that I outlined under the economic policy study, and they would put this burden on the savings of middle-class Americans today.

And they also have the ability, as they go to the White House, to think about whether or not Medicare is going to be included in the discussions around the debt limit. It sounds like they're reconsidering that. I hope they are. They can also understand that they can build on the trillion-dollar -- about 700 -- a little over \$700 billion that they've adopted in Medicare savings for their budget that are in the Accountable Care Act.

And so hopefully, we can continue to build on those kinds of savings that come from bending the cost curve for health care for seniors in this country and for the cost of the Medicare program.

Again, I welcome you to the committee and thank you so much for your service to our country.

KLINE:

I thank the gentlemen.

In pursuant to Committee Rule 7C, all committee members were permitted to submit written statements to be included in the permanent hearing record. And without objection, the hearing record would remain open for 14 days to allow statements, questions for the record and other extraneous material referenced during the hearing, to be submitted in the official hearing record.

Again, before I introduce our distinguished witness, I want to make an administrative announcement, the secretary has hard stop time at 12:30. I want to encourage my colleagues that when we get into questions and answers that you try to abide by the five-minute clock so that everybody has a chance.

And again, we expect to be called to (ph) votes momentarily. So let me move to the introduction.

The Honorable Kathleen Sebelius was sworn in as the 21st Secretary of the Department of Health and Human Services on April 28, 2009.

I got the wave down here. Everybody knows who the secretary is.

So the interest of time, Madam Secretary, you're recognized.

SEBELIUS:

Chairman Kline, and Ranking Member Miller, members of the committee, thank you for inviting me here to discuss the president's 2012 budget for HHS. The president's budget ensures Americans live within our means. And to lead-up to the budget, we looked at all of our programs, cut waste, eliminated programs that weren't working well enough, redesigned our programs to put a new focus on result.

And in some cases the cut programs we would have kept in place in better fiscal times. At the same

time, our budget protects the investments we need to keep Americans prosperous in the years to come. From investments and Head Starts, our kids can compete with those in any nation to investments in biomedical research that allows the US to continue to lead the world in discoveries of breakthrough cures and treatments.

Today, I want to focus my oral testimony on some of the provisions in our budget that will benefit the youngest and the oldest Americans. But first, a quick update on the implementation of the Affordable Care Act. Thanks to the steps we've taken so far, children can no longer be denied coverage because of their pre-existing health conditions.

Families have new protections with the Patient's Bill of Rights; businesses are getting some initial relief from the soaring health-care costs, and seniors have better access to prescription drugs and preventive care.

Tomorrow, we'll announce that more than 18,000 Americans who've been shut out of the insurance market are now taking advantage of the pre-existing insurance plans in their states. Some states are still reporting figures so those numbers could go higher, but that's about a 50 percent increase in the last couple of months as people begin to learn about the program.

It's encouraging to see that more people who need health insurance are getting it. But we know that's not enough. And that's why we're continuing to work with states and national advocates to reach eligible people and let them know coverage is available.

We're also working with insurers that have chosen to notify people about the pre-existing insurance plan when their applications are denied. And we're evaluating ways to reduce premiums and ease eligibility standards to expand access to the plans.

For many, these plans provide access to life-saving treatment. So it's vital we continue to find those who are eligible and get them enrolled. Our budget builds on the momentum of the Affordable Care Act with critical investments to provide for and protect our most vulnerable citizens.

We know there's nothing more important to our future than the healthy development of all of our children. Science continues to show that success in school is significantly enhanced by higher quality, early learning opportunities.

Earlier this year, we got the results of the latest study to look at the value of early education. Researchers followed children from low-income families enrolled in Chicago early education programs until they turn 26, and found that over that child's lifetime, the program generated as much as \$11 in economic benefits for every dollar spent. And that's a huge payoff.

So even in tight budget times, our budget makes room for new investments in child care and Head Start, which have a long history of bipartisan support. But the budget does more than provide additional resources.

It aims to raise the bar on quality in childcare and early education, by supporting key reforms to transform the nation's early childhood system into one that fosters healthy development and gets children ready for school. Quality child care is more than just providing babysitting.

It supports healthy child development and school readiness. And that's why our budget puts forward principles for legislation reauthorizing the main childcare program: the Child care and Development Block Grant.

These include promoting better health and safety standards, putting more information about the quality of different child care option into parents' hands and improving workforce training, to make sure that the people caring for our kids have the skills they need.

We look forward to working with this committee, Mr. Chairman, as you consider these issues.

We're also promoting better quality in Head Start using new evidence-based evaluations in classrooms, including a tool that will help Head Start program see what's working and improve what isn't.

In addition we've revamped the training we provide to Head Start directors and teachers to make sure best practices actually reach the classroom. And we're proposing new rules to require the lowest performing programs, bottom 25 percent, to compete for funding.

By giving programs incentives to raise the quality of their services and removing the weaker programs, we want to ensure that the best programs are the ones serving our children.

Finally, we're pleased that the F.Y. 2011 budget included funding to allow states to fund innovation and early education. In our 2012 request, it includes \$350 million to continue this key investment.

Taken together, these initiatives are designed to create an early learning system that gets every child ready for school, supports healthy child development and features high standards whether the child is in a pre-K program; a Head Start center; a childcare center or a family day care home, to help ensure that American children start school as prepared as any in the world.

Our budget also focuses on creating safe environments for children and families. We thank the committee for reauthorizing the Child Abuse Prevention and Treatment Act and the Family Violence Prevention and Services Act last year.

And our budget includes more than \$200 million for the child abuse and domestic violence programs authorized by these laws. The budget also provides critical support for seniors. It invests in the care and services seniors needs to stay active and engaged in their communities.

And it addresses the terrible problem of elder abuse and provides funding for caregiver services that gives family the peace of mind and enable them to continue to care for their relatives.

These goals guide our department's work on the reauthorization of the Older Americans Act coming up later this year. For more than 45 years, the Older Americans Act has enjoyed broad bipartisan support.

In the past year alone, the law's comprehensive home and community-based system has supported nearly 11 million seniors and their family caregivers. But the need for this kind of support continues to

grow rapidly. Every day more than 9,000 baby boomers turn 65. That's nearly 3.3 million a year many of whom will be ultimately cared for by their family members.

We need to do all we can to help families caring for their loved ones and the Older Americans Act gives us the tools to do just that. We look forward to working with this committee to reauthorize the Older Americans Act and build upon the law's long record of success in serving our families and our communities.

The 2012 budget makes tough choices and smart target investments today so we can have a healthy, stronger and more competitive America tomorrow. That's what it takes to win the future and that's what we're determined to do.

Thank you, Mr. Chairman, and I look forward to our discussion.

KLINE:

Thank you, Madam Secretary. We're getting updates on votes every few minutes. It looks like the latest, "yes" and it's around 10:30. So we will start with the questions and go until we get called to vote.

I know there are going to be a lot of questions about health care and I'm tempted to jump in and start asking those, but I want to go in a little bit different direction, Madam Secretary.

The most recent Head Start impact study says that, quote "The advantages children gain during their Head Start in age four years yielded only a few statistically significant differences and outcomes at the end of first grade for the sample as a whole," close quote. Can you expand that at all? Have you been looking into that?

And then as a follow-on, I'll just get them both out there, again, the latest Head Start impact study states that quote, "There was no strong evidence of impact on children's language, literacy or math measures at the end of kindergarten or at the end of the first grade." Can you tell us what you're doing to get on that? It's a vexing problem that we've been looking at for a long time.

SEBELIUS:

Well, Mr. Chairman, I think that we certainly share the goal of making sure that both the child development and the early learning skills are focused on in all of our childcare and early education program, and Head Start is key among them.

Early Head Start and Head Start continue to show improvements in child development and in learning skills but how long they last into the school life continues to be determined. So we're continuing to take that information very seriously. As I said in my opening statement, to revamp both the teacher training, to upgrade the quality standards, to make sure that we are reanalyzing the curriculum -- the core curriculum in childcare.

But I think studies continue to show that early learning program do make a significant difference in 3-year-olds who spend a year in Head Start have a significantly different impact when they go into grade

school than those who don't. What we need to do is continue that progress once they hit school.

KLINE:

Let me follow up just a little bit. I think that probably everybody on this committee has observed and would agree that early learning is helpful. But my question is specifically talking about Head Start where the quote was there was no strong evidence of impact on children's language, literacy or math measures at the end of kindergarten or at the end of the first grade.

So those efforts that you're undertaking, I hope, are focused and will prove to be fruitful in Head Start, because I think we've been disappointed many times that the Head Start program is not really helping that many kids be ready for first grade.

SEBELIUS:

Well, I would say, Mr. Chairman, we have an unprecedented effort underway right now with the Department of Education, where we are working very closely with them to kind of align standards, to make sure that the early childhood programs run by the education system have the developmental aspects that I think have been a component of Head Start, and that the Head Start programs have the curriculum-based component that often were more focused on in the education programs.

We think that regardless of where a parent chooses an appropriate out-of-home placement for their child, whether it's childcare, or Head Start, or Early Head Start, or a public pre-K program, we should have the same goals and the same alignment of initiatives.

So we are taking those issues very seriously. We think school readiness has to be an important component of Head Start, and we continue to upgrade the programs. We're also re-competing programs that have the lowest 25 percent of the impact on children.

We think that's an important aspect to make sure that we continue to drive improvements and not just continue to fund programs because they've historically had funding.

KLINE:

Thank you. I'm going to move to another subject quickly. Your agency administers the early retiree reinsurance program, which provides money to employment-related retiree benefit plans. An HHS report, dated March 31, 2011, said the program was supposed to last until 2014 had already spent \$1.8 billion and is not accepting new applications as of the end of April.

This is troubling on a number of levels. I'd like to know if it's true that one plan sponsor, the United Autoworkers Retiree Medical Benefits Trust received \$207 million or 11.5 percent of the total amount made by the program.

During the plan approval process, did this plan have to demonstrate or prove that it needed taxpayer funding to pay claims or maintain solvency? I have a number of other questions relating to this but I think you can see the point. We're concerned how these decisions are made or how this money is awarded. Can you address that specific?

SEBELIUS:

I'd be glad to, Mr. Chairman. I can't answer with specificity about the UAW plan. I'll be glad to give you the written answer to that.

KLINE:

Would you please?

SEBELIUS:

I just don't have those facts at the top of my head. But this program has been enormously both popular and helpful, I think, to those companies and programs who wanted to continue their early retiree coverage.

We've seen employers consistently dropping that coverage over a period of time and in fact one of the largest growing groups of uninsured in America were the 55 to 65 years old, who retired early and they and their spouses often lost that employer-based coverage when those plans got too expensive.

This program was widely advertised, announced. There was a process where applications were accepted universally; they had to present documentation to our office. It wasn't our office picking and choosing who got in. The programs qualified if they met the statutory qualifications. And the way this works, Mr. Chairman, is individual claims are presented that rise above the threshold. So it's a stop-loss policy, if you will, for early retiree programs.

The most expensive claims are presented and they are paid. We share 80 percent of those costs. So we give employers some ability to predict their costs going forward and that has actually stabilized the early retiree plan.

So plans are not being paid from a presumptive pipe line, we are actually paying after the fact as claims are being presented. And we'd be happy, again to share the documentation of how that's working. It's paid six months after the claim is made. They come in and the money goes out the door.

KLINE:

OK. I'll present some questions for the record. (inaudible) it looks like we're going to run out of money and if you requested that money in the president's budget and so forth, I'll present those for the record and then...

SEBELIUS:

I would be glad to answer that.

KLINE:

... recognize Mr. Miller forward (ph).

MILLER:

Thank you very much. Just on the Chairman's earlier discussion on Head Start, I don't know the study he's referring to but I know on previous studies, the question that had to be asked was what was the quality of the program the child was entering into in kindergarten or first grade?

We know that many of these children in, unfortunately, the poor performing schools, the poorer schools in our country, they can lose a whole year over the summer. And so the idea, you know, it's whether you follow on with after Head Start that has - determined but I'd be glad to look into the studies. But I know in the past that has been a significant impact on what happens to children afterwards.

I want to turn to part of the Affordable Care Act that I had a chance to participate in my district last month and that was the partnership for patient's initiative, which is really about, as I witnessed this is this is an effort to try to reduce medical errors, to improve care, to stop the accidents that take place, to improve the sanitary nature of a hospital from washing your hands to a whole range of things that were popularized, I think, to some extent by Gwandi (ph) and making the list before surgery and what you should be thinking about when you're doing that.

I was quite surprised that at the range of support for this program, from the Chamber of Commerce, to the business roundtable, after the event the profits, nonprofits and public facilities all wanted to say, how do we get to participate in this. And in the San Francisco Bay Area, there's quite an array of hospitals from the most successful nonprofits to the Kaiser system of a prepaid nature and then to public facilities.

My understanding is that it there's about 90,000, somewhere of 95,000, 98,000 people who die in the care of hospitals or shortly thereafter as a result of their mistakes that are made. In the facility that we visited, a question of hand washing all over the time, as you move from room to room, from facility to facility. They had a simple plan of putting bright red tape behind the head of the bed so that those who are on respiratory assistance, the bed is kept at 30 degrees.

Dramatic reduction in pneumonias in that facility. People who are susceptible to slips and falls now have to wear very bright red socks and slippers so that people are aware of that. Slips and falls have gone down about 50 percent. It's just ricocheting through the system in terms of the improvement in the outcomes in that facility.

I think your agency has said that we left for savings down the road of about \$50 billion under this initiative. But it's very clear, from people who are paying the bill, the employers and others who are participating in this that there is a pretty big debt being placed on improving these outcomes.

There is a piece on the Wall Street Journal last week that even with all the admonishment as medical staff moves from space to space, there is over -- a vast majority of them are still not washing their hands.

Those of us who visited the veterans at the veterans' facility know every time you move between one space to another, whether you touched anything, you have to go through the sanitizing of your hands

as you move around that facility.

And I'd just like your comments on this because this seems to me given the people who are rushing forward to say we haven't yet been able to participate who want to participate in this program.

SEBELIUS:

Well, Congressman Miller, we've had enormous enthusiasm and excitement as you have indicated across the range of not only health care providers but employers, business groups, patient advocates.

We do have about 100,000 deaths a year, but hundreds and hundreds of thousands of people are injured. And in fact, the most recent study said that one out of every three Americans who goes into a hospital is injured by care that they received in the hospital.

That's a very large number and it not only causes enormous injury and death, but it costs an enormous amount of money that we shouldn't be spending. In the past, Medicare has been a volume purchaser. So whether the hospital had a 60 percent infection rate or a zero percent infection rate, it basically got paid the same way.

The Affordable Care Act gives us a framework to actually begin to head in a very different direction, to use the enormous payment system of Medicare and Medicaid, to be a cost driver to encourage value instead of volume and we're taking that very seriously.

So the partnership for patients has two very aggressive goals: reduce hospital-based infections by 40 percent over the next three years. The ultimate goal is zero. We shouldn't be hurting people when they go to the hospital. That has to be our goal. And reducing unnecessary hospital readmissions by 20 percent over the next three years.

And those goals are achievable because there are pockets of that care going on right now in the country. So we're going to be providing technical assistance; sharing best practices; helping to encourage. But as you say, we currently have over a thousand hospitals who have signed up. We have employer groups, we have patient advocate groups, a range of partners.

And frankly the private sector is enormously enthusiastic. They have been trying to do this for years but they don't have enough juice in the system. They can't touch every hospital with their purchases. So joining together on quality outcomes, not only improves care for Americans but dramatically lowers costs.

We have two ways to lower the rising cost in Medicare: it's improving care and getting a better bank (ph) for our buck and lowering cost that way or just cutting off benefits. And I think the partnership for patients gives us a real pathway to a new kind of delivery system change.

MILLER:

Thank you.

Thank you, Mr. Chairman.

KLINE:

I thank the gentlemen.

Dr. Foxx, you're recognized.

FOXX:

Thank you, Mr. Chairman, and thank you, Secretary Sebelius, for being with us. I'm interested in hearing what Mr. Miller was saying and talking about all these wonderful things that have happened over using common sense. It's just -- what's astonishing to me is that it's taken so long for the department to be able to put in common sense in issues like this.

It seems the federal government doesn't often care about cost until our backs are against the wall. And we ought to be caring about cost every day in every program. There should be accountability in every program every day. And it's disappointing to someone like me who cherishes common sense that it's taken so long to get to this point but let me get to my question now.

I find it really interesting, Madam Secretary, that you and the president said over and over and over again that if you like it, you can keep it. You promised the American people that if they had health insurance that they could keep what they had. But we now know that although you promised people to be able to be grandfathered in, the regulation that you published last year found that 69 percent of employers and 80 percent of small employers will lose their grandfather status by 2014.

So what you said wasn't true because you have established regulations that were not in the law to guarantee that people can keep their health insurance. So how do you reconcile what you promised with what you've put into effect and the fact that this is going to cost so much more money as a result of it?

SEBELIUS:

Well, Congresswoman, I first of all share your concern that common sense doesn't always drive policy. The error report came out 10 years ago indicating we had a serious safety problem and frankly, no one paid a lot of attention to it in the Medicare agency. And I'm pleased that finally the Affordable Care Act presented the platform to allow us to have the kind of regulation in place that moves in a brand new direction.

In terms of the insurance market, as you know, employer participation in the market is voluntary. And small business owners and particularly individuals move in and out on a regular basis. And you're absolutely right. The law doesn't mandate that employers who had a policy in place in 2010, when the bill was signed, must keep that policy in place. That is not part of the law so they still have free will and free choice.

What we did do is create a platform that said, basically, if you keep essentially the same kind of benefit package, if you don't shift to a huge amount of cost on to your employees; if you don't

dramatically cut the kind of benefits that your employees now are able to access, then you are grandfathered in under the plan.

And so it's really an employer choice whether or not the grandfather status is going to meet them on into the future or not and that's really way the private market works. The employers come in voluntarily; they may or may not provide coverage.

We're seeing actually, I think, some good news where small employers are beginning to re-enter the market for the first time in a very long time. We were on a trajectory where if you work for a small company, and I certainly saw this as an insurance commissioner in Kansas and I heard about it over and over again when I was governor of Kansas that the most vulnerable people in the marketplace where folks buying individual coverage and folks -- farm families and small mom- and-pop shops who were in the small group market and that market is beginning to stabilize and I think that's very good news.

FOXX:

But, Madam Secretary, why don't you just leave free choice out there, period? It will be up to the employers to decide what they can afford to do and it would be up to the employees to decide whether they want to go on the private market themselves. Why not allow that free choice? You all along, your side of the aisle have very limited issues on free choice.

SEBELIUS:

Well I think, again, the platform of the Affordable Care Act, Congresswoman, is that employers particularly in the small- market have to look forward to a new competitive lower cost marketplace according to the Congressional Budget Office.

They will have a choice and the cost for those premiums will go down. They currently have very limited choices in the marketplace and often pay 18 percent to 20 percent more than their large competitors just because of the size of their companies.

So they'll be in a large pool, they'll have some choices. Individuals also will be able to purchase coverage and have some assistance purchasing that coverage if they're lower wage workers if they don't have access to employee coverage.

So we have a market that will be framed by states around the country that doesn't exist right now and gives a lot more choice and a lot of cost relief to the most vulnerable folks in the marketplace.

KLINE:

Thank you.

Mr. Kildee.

KILDEE:

Thank you very much. Madam Secretary, Head Start when it was first authorized in 1965, placed a program in HHS rather than the Department of Education because it was more comprehensive than just education to include health and other social skills among others.

I was, too, a sponsor of the 2007 reauthorization of Head Start and we tried to enhance those purposes that we pushed forward in 1965. How has the fiscal year '12 budget helped you in your efforts to bring these programs, integrate them together the various purposes beyond the purpose of education in the Head Start program?

SEBELIUS:

Well, Congressman, I think that the president certainly shares your belief that Head Start is a very important component of an early childhood framework for America and that's why he has proposed an increase in Head Start funding as we move forward and the ability to serve additional children.

I think also the notion that we have a very exciting opportunity with the passage of the 2011 framework, the early learning challenge fund, which will be housed in the Department of Education but participated in by HHS and Education, which actually is kind of a near-race to the top for early childhood education, driving quality initiatives, aligning the kind of standards and giving states the opportunity to really innovate in early childhood education.

And what we're seeing around the country is that Head Start is no longer operating in a silo (ph) but many governors have put together a broad-based early education cabinets where the Head Start folks are very much at the table with the early childhood education folks with the child care folks, which was almost unprecedented.

And I know I did that, again, when I was in Kansas but that's a mirror of what's happening and I think the integration of developmental skills, one of the features of Head Start that I think is very critical that again needs to be incorporated into a lot of early childhood programs is involvement of parents.

There is a significant parental aspect to Head Start where they participate in a child's education at the earliest point and hopefully that continues on so there are a number of components which not only look at school readiness but look at the whole developmental readiness of a child that we are trying to improve and actually share with our partners in the education system.

KILDEE:

Thank you very much and I encourage you to encourage the governors and those in the states to continue to do that. Thank you very much.

KLINE:

The gentleman yields back.

I'm going to recognize Dr. Roe in about 3 seconds. And for everybody's information, his will be the last question as we head to the floor to vote, just alerting all the members of the committee.

Dr. Roe, you're recognized.

ROE:

Thank you, Madam Secretary, for being here today and to let you know that my background as a physician, practicing in Tennessee, what we had (inaudible) was an expansion of our Medicaid program. And the first question I have is how many people are there that the Affordable Care Act cover -- that you estimate right now they will cover?

SEBELIUS:

How many new people?

ROE:

Yes.

SEBELIUS:

The estimates are in the 30 to 35 million range.

ROE:

It looks like that most of this expansion in coverage is just an expansion of Medicaid.

SEBELIUS:

Doctor, the data that I have seen is estimated at about half and half. About half will be exchange-eligible and about half will be Medicaid-eligible, so about 15 million are likely to be Medicaid-eligible.

ROE:

What CMS said is that 24.7 million will be added, an increase of 5 million. These are Medicaid. This is not me, this is CMS. And CBO estimates 8 million more than we had thought. Do you agree with those what CMS said or what the CBO said about their estimates?

SEBELIUS:

Again, the numbers that I'm familiar with are about half and half. So I'm not sure quite what you're looking at...

ROE:

I'll send some...

SEBELIUS:

It may be who's uninsured and there are a portion of uninsured that aren't assumed to be fully insured, I mean, I don't know.

ROE:

I'll get those in written form to you.

SEBELIUS:

OK. Thank you.

ROE:

Do you think this bill is simple or is it complex to understand and have you read the whole bill?

SEBELIUS:

I have read the bill. I think it's very comprehensive because it deals with all aspects of the health care system.

ROE:

Let me get down to just some practical aspects of it. I have a practice that has about 350 employees, eight (ph) primary care doctors. And we insure about 300 of them. And everybody's eligible. We have done that for 40 years in our practice. Very proudly, we have provided health insurance coverage, retirement and so forth.

Right now we pay about \$5,500 per employee or somewhere and maybe up to \$6,000. I haven't seen the number for this year. If someone goes to the exchange and we decide to pay the \$2,000 penalty, we save ourselves in our practice a million dollars.

That's one little business. Another business in Tennessee that I've seen and talked to those folks, because we don't know what -- I know someone -- this is another question I'm going to have is who defines what an affordable care is. What is that? What's in the package?

This company will spend they think \$40 million more in their business complying with these new regulations or they can save \$40 million by having those folks get their health insurance through the exchange.

Now we had a very good presentation and you probably should read this from the Lockton group. Mr.

Brewer came in, the president of Lockton group and went over the case, example after example about why that will happen. So why wouldn't I do that under this situation?

And like you said, most of his clients told him, "I'm not going to be first to do this but I'm not going to be third," and finally what's going to happen is you're going to have a debate between his chief financial officer and the HR people. I've done it around the table. And finally, the chief financial people win. So tell me why that's not going to happen?

SEBELIUS:

Well, I think Congressman, one of the things that assumes is that there is no advantage to a business owner for keeping great employees and tying those employees to a health insurance plan. What we see right now is a voluntary marketplace where people have entered voluntarily.

Your premise is based on the fact that that employer, you, in this instance or somebody else, drops all the employers' coverage...

ROE:

(inaudible) over 200 employees now which we are. Almost all of them provide health insurance coverage right now. And as you see reimbursements, especially in our business with Medicaid going down and with Medicare, I hope I have time to get into Medicare, why wouldn't I do that?

SEBELIUS:

Well, again, I think that the exchanges are particularly being designed for small employers. You, in the instance of having the number of employees that you're talking about, are likely to be banned from initially entering the exchange because of the...

(CROSSTALK)

SEBELIUS:

Pardon me?

ROE:

They can. I mean I've read this. We can do that. If one person goes in there and we decide to drop - anyway, that's fine. I'm not going to get an answer.

The other question I have is in Medicare, I'm particularly worried about because health care decisions, I believe, Madam Secretary, shouldn't be made here in Washington, D.C. They should be made between patients and their families and their doctors, not by insurance companies and not by the federal government.

SEBELIUS:

I absolutely agree.

ROE:

And my concern is we've just taken \$500 billion out of an already underfunded Medicare plan. And your number is -- 3.3 million people we're adding per year. That's another 30 million, 35 million people in the next 10 years with \$500 billion less. How does that math work?

SEBELIUS:

Well, Congressman, as you probably recognized, the \$500 billion is a reduction in the growth rate of Medicare from what's estimated to be about 7.8 percent to closer to over 6 percent. So it is not taking money out of the program. It actually is trying to slow down the cost growth without changing any of the guaranteed benefits and indeed there are additional guaranteed benefits.

I would suggest that the House passed budget -- the House Republican budget that suggested that vouchers are the appropriate goal for Medicare. And turning over Medicare patients to the private insurance market does nothing but shift enormous costs on to seniors in this country. Putt an insurance company between them and their...

(CROSSTALK)

KLINE:

Madam Secretary, I hate to interrupt.

Dr. Roe, the clock is demanding here. We, the committee, is in recess.

(RECESS)

KLINE:

The committee is called back to order.

By agreement, with my colleagues, we are going to resume. I understand Mr. Miller will be joining us shortly but I recognize Mr. Andrews for five minutes.

ANDREWS:

Thank you, Mr. Chairman, and welcome, Madam Secretary, to the committee. It's very, very wise, Madam Secretary, to be listening to Takida (ph). I would to. She's a very able and wise young lady. And from the right state, I might add.

Madam Secretary, one of the topics of the moment for the country is Medicare and how we should respond to the long-term bargain our country made with our seniors and persons with disability in 1965.

That bargain of course was that when a person retires or is adjudicated to have a disability, they will be guaranteed medical benefits; they will be guaranteed the choice of their own physician and Medicare will pick up the lion's share of that bill. And that's a system that I think has worked very well for this country for a very long period of time.

As you know, there are proposals that would, in my view, end that system. It would say to people 55 years and under that they are going to be into a very different system that is essentially a subsidy and an inadequate subsidy to buy private health insurance.

The report that Mr. Miller spoke of earlier indicates that if one takes the gap which the Congressional Budget Office has identified between the premium support that the Republican plan would offer and the real out-of-pocket cost for health care for retirees and seniors would be about \$6,000 a year.

And for a senior to have enough money to cover that gap, he or she would have to save nearly \$200,000 out of their pocket before they retire. One interesting point of reference is that the average 401(k) balance per person when they retire in this country is a little less than \$100,000 a year.

So what that means is if you are a senior under the Republican Medicare plan, at least the one that existed until yesterday, and you emptied your 401(k), it would only make up about half of what you need to pay your out-of-pocket health care bills -- additional out-of-pocket health-care bills because of the Republican plan.

Now I know that before you came here, your experience as governor gave you -- back in Kansas, generally gave you the opportunity to be an insurance market regulator. I wonder if you could tell us what you think would happen in addition to this financial disaster, what do you think would happen to people 65 and over and people with a disability if they were thrown into the private insurance market with this kind of inadequate subsidy, what would that mean to a senior citizen or a person with a disability?

SEBELIUS:

Well, Congressman, I've seen the same analysis that you have. First of all, Medicare as a program has one of the lowest administrative costs of any health program, I would suggest, in the world. So we know that according to CBO, according to any economist that the administrative costs of an average health insurer are significantly higher. So you take the same amount of dollars and you have less buying power if you're doing it through the private market than you do through Medicare.

Secondly, to have a fixed-dollar amount as opposed to guaranteed benefits, I think is, as you suggest a very different kind of commitment to seniors and leaves an enormous cost shift on to the seniors and those with disability.

ANDREWS:

Can I just interrupt for a minute? What might that cost shift and lack of guaranteed benefit mean for an oncology patient, a person with cancer? Give me an example what it might do there.

SEBELIUS:

Well I think there's no question. If you take a snapshot, people will run out of money very quickly and if you run out of the government voucher and then you run not of your own money, you're really left to scrape together charity care, go without care, die sooner.

There aren't really a lot of options but it's estimated, according to the CBO analysis that by, I think it's 2030, you would have about 70 percent of the cost of medical care shifted on to individuals. Pretty dramatic. Right now it's about 25/75 and that would flip pretty dramatically.

And most people or a number of people, working families and others don't have the wherewithal to come up with that kind of cash, particularly in their later years when they're likely to have more serious and more expensive care.

ANDREWS:

It's true, isn't it, that the Republican plan that was adopted by the House majority about two weeks ago really isn't a cost reduction plan? It's a cost shifting plan. That as health care costs go up, seniors pay more and Medicare goes away.

SEBELIUS:

Well, I think the combination of the votes on repealing the Affordable Care Act which would not only get rid of the new tools we have to crack down in fraud and abuse but limit the closure; eliminate the closing of the doughnut hole; go after her some of the new guaranteed benefits combined with the voucher program would basically destroy the commitment to ongoing health care.

As you say, one of the promises made in 1965 and a little personal anecdote. My father was actually on the energy and commerce committee serving in Congress and helped to write the Medicare law. He's now -- he just had his 90th birthday and he's pretty happy with those benefits right now.

ANDREWS:

We'll tell Mr. Dingle (ph) that.

SEBELIUS:

Well, he served with Mr. Dingle (ph) and he knows Mr. Dingle (ph).

KLINE:

So do we all.

(LAUGHTER)

SEBELIUS:

Yes, indeed. But I think it's a very different kind of commitment that we would be making to 55-year-olds about their future in the United States.

ANDREWS:

Thank you, Madam Secretary.

KLINE:

Thank you, gentleman.

Mr. Walberg, you're recognized.

WALBERG:

Thank you, Mr. Chairman, and thank you for joining us, Madam Secretary. As you may probably already know, since 1992 the National Institute for Occupational Safety and Health and National Cancer Institute have been working on a study that determine the potential health effects of diesel exhaust on miners. Members of the mining industry voluntarily provide NIOSH with the access and information to conduct the study.

Initially, NIOSH agreed to share data with the companies and volunteered access and information. However, since that time, NIOSH has not honored that agreement on more than one occasion. As a result, federal judges twice have ordered NIOSH to share these materials with the concerned parties, which include this committee. Yet full compliance has yet to be seen.

And so the questions I would ask would -- I'd like to know why NIOSH has not complied with these orders of two federal judges and I'd also like to know what assurances you can give me that the data will be released as required by the courts. In other words basically do you want NIOSH to comply?

SEBELIUS:

Well, Congressman, I must confess I am not familiar with the studies that were done or the federal cases but I will commit to you that I will learn about them quickly and, you know, work with you to get you the information that you've requested. I just can't respond about why they haven't done it. I'm not - I wasn't aware that they had not but it will be something that I will...

WALBERG:

If the court has ordered these, I would hope I can conclude that you would want them to comply.

SEBELIUS:

Well as I said, Congressman, I'm not familiar with the situation. I will get very familiar with the situation and I will get back to you quickly.

WALBERG:

I appreciate that. Moving back to Chairman's leadoff questionings with Head Start, last year the U.S. Government Accountability Office conducted an undercover investigation of 15 Head Start programs acting in response to tips from former and current employees at two separate Head Start centers.

Undercover GAO applicants tried to enroll children in these programs and presented the centers with paystub data that demonstrated they were above income eligibility requirements. Nine of the 15 sites enrolled the students anyway by encouraging applicants not to submit the pay stubs that would put them over the income threshold.

Some of the programs continue to account students as enrolled even though the students never actually participated in the program. And in May 2010 hearing before this very committee, the assistant secretary for children and families stated that the department was taking immediate corrective action and was undertaking a top to bottom review of its program oversight responsibilities.

So the questions I would ask are these: can first, you give us an update on the department's effort to combat waste, fraud and abuse in the Head Start program? And secondly, how many unannounced monitoring visits has the department conducted since the release of the GAO report?

SEBELIUS:

Congressman, first of all, I want to tell you that I share your dismay at the GAO report and more than the GAO report, the practices that were underway and we do take program integrity very seriously.

In fact, I have, for the first time, created a Secretary's Program Integrity Council which operates across all of our agencies and departments to try and actually get out ahead of any practices, any lax oversight, any issues that we should know about. We did very quickly go into -- first of all, we've had -- I think I was told yesterday 160 unannounced visits, to answer your question with some specificity about that and those are ongoing efforts to make sure we're complying with that.

We've conducted re-training of Head Start directors; we've issued new guidance on compliance with program integrity and guidelines and reminded people about their legal responsibilities. We are re-competing as I say. We put out a rule about re-competing the lowest 25 percent of the program.

We're conducting overall reviews and ongoing training initiatives but we're taking this very seriously reminding people that these are taxpayer dollars and being used to educate some of our most vulnerable children and we want to make sure that that's exactly where the dollars go.

WALBERG:

I appreciate that and we look forward to receiving fuller information on that. But in a time of vanishing dollars for our educational systems, in my state as well as your state, we can't afford this to take place. So thank you.

SEBELIUS:

I agree.

WALBERG:

Thank you, Mr. Chairman.

KLINE:

I thank the gentleman.

Mr. Payne.

PAYNE:

Thank you. Let me commend you for the outstanding job you're doing. I think one thing we need to keep in mind is that it's great that the United States of America has moved into the nations around the world of developed countries to provide universal health care.

As you know, we are one of the only developed countries in the world that did not provide it. Let me just say about Head Start, as we know, it's a vital program that helps to level the playing field for lower income preschoolers and improve academic outcomes. We know there are some problems we have struggled (inaudible) so to speak.

In your testimony, you mentioned the department's endeavor to strengthen its start (ph) programs and I commend you for efforts as well as your continued support of childhood education in F.Y. 12 request.

Our Republican colleagues proposed the \$690 million cut to Head Start this year, as you know, which would have removed 130,000 low- income children and families from the program; closed 10,000 Head Start classrooms; laid off 33,000 teachers and related staff. This measure is contrary to our goals of increasing employment and strengthening educational outcomes.

Thankfully, this measure did not become law and our children, like a little fellow named Matthew in my district, sent me a constituent letter saying, "Dear Congressman, it's my future. Hands off. Head Start funding." As a matter of fact, Matthew had his little handprint to just keep your hands off of our funding. I have to have a meeting with him. I hope it doesn't come to a town hall meeting and run me out of the place.

So we know that it's very important and (ph) I really commend the administration and support your F.Y.12 budget. Let me just say an addition to proposing cuts to Medicaid, my Republican colleague supported a spending plan that would turn Medicaid into a block grant program.

Medicaid provides health care for the most vulnerable population, the elderly, disabled children, low-income adults. Madam Secretary, can you explain the impact of this action? What would have had on the beneficiaries and states if it had gone into effect?

SEBELIUS:

Well, Congressman, our analysis of the budget proposal is that, as you know, not only does it propose a block grant but there is a significant and very dramatic decrease in the funding levels so it's a fixed cap that decreases over time. And frankly, again, as a former governor who administered the Medicaid program, one of the things that you can't anticipate is, you know, two years out, what the economic downturn is going to do.

So just a little bit of hindsight, if we had had a block grant in place for Medicaid recipients over the last number of years and the increase in services needed based on the number of people who lost their jobs, lost their healthcare needed reliance on that, I think most states would have been in a very more dire situation than they are right now.

As you know the vast majority of the Medicaid population are children. The most expensive population are older Americans who are poor enough to qualify for Medicare but often are in nursing homes and you don't have a lot of flexibility -- people don't go away when the money goes away.

So I've met with mayors and some governors and county supervisors and others who find this proposal to be very alarming because they will still deal with folks coming through the doors of emergency rooms without care. They'll be dealing with people in nursing homes without the support that Medicaid currently provides for that very critical nursing home care.

What we think is a much more strategic way to deal with this is 5 percent of the Medicaid beneficiaries account for about 50 percent of the cost. They are the most chronically ill, often disabled. Many of them are getting very erratic care.

They are often in two systems: Medicare and Medicaid at the same time. And we are working very closely with states and with the proposal that's going to come out of our new center for innovations that will focus on the so-called dual-eligibles and give states a lot of flexibility of using the best possible practices to coordinate care and actually drive those costs down.

If we can cut those costs by 10 to 15 percent, states will save billions of dollars and the federal government, frankly, will save billions of dollars.

PAYNE:

Thank you very much. I don't know if I have time for another question. Well, still on yellow.

During a debate in H.R. 1, Republicans adopted nine riders and tenants (ph) to block implementation

of all of components of ACA. If enacted, these amendments would have brought implementation of the ACA to a halt, eliminated benefits that people throughout the nation are already enjoying, including many of my Republican colleagues and constituents.

Can you quickly mention some of the benefits that already have been experienced as a result of ACA?

SEBELIUS:

Certainly, Congressman. I mentioned the children with pre-existing health conditions, which I think is a huge step forward for families who have been struggling with that, being locked out of the insurance market for years. We have already seen the reports of just the last month are that hundreds of thousands of young adults are now covered.

One of the most uninsured populations in the United States is now coming into the marketplace. Thanks to the provision that allowed our young adults to stay on a family policy for an extended period of time. We know that seniors are beginning to get relief from their prescription drug benefits.

A number of them got the one-time \$250 check, but this year, they'll have a 50 percent decrease that's going into effect. And at the same time they are experiencing lower rates on Medicare Advantage plans. Thanks to the negotiating power that the ACA provided for us.

There's a new Bill of Rights for patients that ensures that new plans have preventive health care that new oversight powers for state insurance departments to do rate reviews. The medical loss ratio goes into effect this year. So \$.80 of every health care dollar has to be spent on health costs and not overhead and CEO salaries.

Those are just kind of snapshots of what's beginning to be underway. The pre-existing condition plan where we now at 18,000 Americans who have been locked out of the market are now able to buy market-based coverage and really, often, in life-saving situations.

KLINE:

The gentleman's time has expired.

Dr. DesJarlais, you're now recognized.

DESJARLAIS:

Thank you, Mr. Chairman. Secretary Sebelius, thank you for being here today. And like my colleague from Tennessee, I am also a physician. And prior to coming to Congress in January, I practiced primary care medicine for the past 18 years in Tennessee and was also a witness to the failed attempt at a government-run motto in the state -- Medicaid program that was known as 10 cure (ph).

And I would love to discuss that but I think, right now what's on a lot of people's minds is the issues with Medicare so I'd like to start with that.

Would you agree that Medicare is an example of government-run health care?

SEBELIUS:

Congressman, Medicare provides for...

DESJARLAIS:

Just yes or no on that one. Is it run by the government?

SEBELIUS:

Yes.

DESJARLAIS:

: OK. Are you going to agree with my colleague across the aisle that said Medicare has been doing a great job for many years now, in fact 40 plus years?

SEBELIUS:

I think it's delivered the essential benefits to seniors for 40 plus years. Yes, sir.

DESJARLAIS:

OK. I just want to share a few concerns that have been brought forth to us in the past few months. One of great concern is that the CBO has estimated that the program will be bankrupt in 9 years if left unchanged. So when we get challenged that our attempts to make changes to this program to secure it and protect it for future generation, sometimes I take issue with that. Also...

SEBELIUS:

As you know, Congressman, the slowdown and the cost growth was estimated to add a number of additional years onto the Medicare trust fund that was provided by the ACA.

DESJARLAIS:

OK. We'll get into that because we're going to talk about slow down and cost growth, but we're also, as you stated, we're entering 9,000 new members into the Medicare program each day or roughly 3.3 million per year. So we're greatly expanding the program and we're talking about bringing down costs. And it's obvious, this a great thing.

Just back from the '70s you all remember the average life expectancy was much less. We're all living

10 years longer than we were just a few years ago but that also has to be accounted for. We have to pay for that. That's been (inaudible) baby boomers, as we mentioned, are coming through the program now so we have huge volume issues.

Also, it's noted that right now an average family, average couple that makes about \$43,000 a year per person has a Medicare tax liability over a lifetime of approximately \$100,000 but yet the average utilization for the same couple is about 300,000. So we have a 3:1 ratio there and all of those things kind of point towards disaster especially when we're talking about bringing more people in yet we're going to reduce cost and somehow were going to maintain quality of care.

What would be your concerns based on those facts that I just gave you?

SEBELIUS:

Well, I think that there are ways that certainly healthcare providers have suggested that we can reduce costs, not tamper with the guaranteed and deliver better care at the same time. And that's really the strategy of looking at the underlying rise in health care costs, whether it's Medicare or the private insurance market or somebody who's paying out-of-pocket.

The trajectory of health care costs, paying more for everything that were doing continues to rise well above the rate of inflation. And yet as you know, Doctor, in the United States, our health results don't show that kind of expenditure. We are not getting the kind of health results we should get.

So I think there are all kinds of delivery system. I mean, Congressman Miller mentioned just one...

KLINE:

I don't mean to interrupt but we have so little time. One of the things that was in place...

SEBELIUS:

I'd like to get you that answer in writing if I could. Thank you.

DESJARLAIS:

OK. Thank you, ma'am. I appreciate that.

One of the plans when Obama care was passed on Christmas Eve, in the middle of the night was that physicians were going to save a 21 percent cut in Medicare. Is that still your intent?

SEBELIUS:

As you know, the president has suggested, since he came into office, that the SGR has to be fixed permanently. He has proposed, again, in the 2012 budget that it be fixed. He's got two and a half years of offset and looks forward to working with Congress to fix it.

The SGR, I think, remains as a major barrier to Medicare beneficiaries, predated the Affordable Care Act continues to be an issue that I look forward to working with Congress to fixing.

DESJARLAIS:

In your testimony on reducing health care costs and increasing quality, you mentioned several times these innovation centers and you're going to pursue, whenever possible, new approaches that will improve quality of care and lead to savings.

As I read through this, I see a lot of assumptions and theories but I don't see anything based on fact. What exactly are innovation centers and how can you assure the American people, when health care system, as we know now, is going bankrupt that we should just take a blind leap of faith that these things are going to work?

SEBELIUS:

Well there is one innovation center, Umbrella and there are already some programs that have been put out in terms of regulation so the Accountable Care Organization is an opportunity for health care providers to voluntarily come together and around the care delivery system focused on Medicare beneficiaries. And if indeed there are savings achieved they get to share in those savings.

If there are no savings, it's a net wash. We don't expend additional funding. There's enormous enthusiasm among hospital systems and provider groups for doing just that.

DESJARLAIS:

But you'd agree these are unproven and untested theories?

KLINE:

The gentleman's time has expired.

Thank you, gentleman.

I'm looking at the clock and we have less than an hour before the secretary has to leave. So I'm going to be a little bit more stringent on the five-minute clock in order to give all of our colleagues a chance to ask a question.

Mr. Grijalva, you're recognized.

GRIJALVA:

Thank you, Mr. Chairman, and thank you, Madam Secretary, for being with us. First, an acknowledgement and then I'll raise a request and just one question. The acknowledgment is to your

staff. They've been very attentive to our office and we appreciate that very much.

Some of the questions that came up regarding the waiver process in Arizona they've been very diligent about communicating with us and giving us the information and we're very appreciative of that. We've been persistent and they have been equally gracious and so I appreciate that.

The concern I have is some of the proposed regulatory changes to Head Start and Early Head Start. I'm concerned that there could be an impact on dual language children. As you know, these a group of children, Latinos in particular are proportionately low enrollment and Head Start and Early Head Start.

As you work through those regulatory changes to diminish fraud and abuse within those programs that should be eliminated, my office look forward to working with you so there's no unintended consequences relative to the participation of those children that desperately need to be part of that program. So that I think is (inaudible)

SEBELIUS:

We look forward to that.

GRIJALVA:

The question is just for historical purposes, talk about, if you would, talk about what you perceive to have been the original objectives of the Medicaid Act.

SEBELIUS:

The Medicaid Act was clearly aimed at providing health care services for some of the most vulnerable Americans. Those who were -- the lowest income children, pregnant women, the disabled who qualify for Medicaid are primarily the beneficiaries of that program in a partnership with state and federal government to deliver those services.

GRIJALVA:

And I asked that question because those objectives continue to be, I think, the guiding principle behind Medicaid.

But do you feel that some of the current attempts by the majority in the House to change the program by rolling back eligibility; the block grant process; making it more difficult for those vulnerable populations to get access to health care, both at the state level and at the federal level?

How do they match up with those objectives?

SEBELIUS:

Well, Congressman, I am very sympathetic to my former colleagues who are governors around this

country and are in a very tough budget times. And balancing a budget is never easy. Medicaid nationally is about 16% of state budget and it's always something to look at.

We have been very diligent working with states around giving maximum flexibility within the law; working on sharing the best practices.

We've got a lot of new governors who have not been in that office before and we've sent teams into 20 different states to work on what their snapshot looks like in ways that they can save dollars. But I think the administration is continuously committed to providing health care services to those very vulnerable populations.

We want to do it in the most cost effective and frankly the most high-value method possible and that isn't going on in every state around the country. So what we can do is work with states to try and figure out ways to stretch those dollars but provide those essential services because the folks aren't going to go away.

If the federal government decides to shift cost, they just shift on to states, to local governments and ultimately on to people who end, you know, on the streets or in a jail or under a bridge because they don't have the support system that they need to stay healthy and stay productive.

GRIJALVA:

Thank you. And the collaboration with the Education Department around Head Start because Head Start is more than just education. It's a whole child program. One of the discussions I think is important, if I may suggest, is programs like Even Start that extend that literacy to the whole family. One of the programs that educations indicated that they want to eliminate is part of a component that I think merits the discussion.

And thank you very much. I yield back.

KLINE:

I thank the gentleman.

Dr. Bucshon, you're recognized.

BUCSHON:

Thank you, Mr. Chairman, and thank you, Secretary Sebelius, for being here today. I'm also a physician, cardiothoracic surgeon for the last 15 years and I have a bunch of questions so I want to try to be brief. You stated that Congressman Ryan's plan put seniors on the open market. Are you aware that it's designed after the same type of health care plan that members of Congress currently have? And would you call that the government putting members of Congress on to the wide-open private health care market?

SEBELIUS:

Yes, I mean, you are in a negotiated federal employee...

(CROSSTALK)

SEBELIUS:

... you don't have a fixed amount of money.

BUCSHON:

Do I have to go to my local insurance agent with government money and pick my health care plan, or do I have a book about the stick (ph) with multitude of options from which I can choose that I've had -- let me finish -- that I've had negotiated, rates that are competitive, because to participate in the program as a health insurer, you have to be competitive.

This is the same proposal that Chairman Ryan has for seniors and is clearly deceptive to say to the American people that this is putting seniors into an open health care market when in fact you know that that's not true.

SEBELIUS:

Well, I do think it's putting seniors. Right now, they can choose their doctor. They can choose a program they can (inaudible)multiple doctor. In an insurance plan, often, the doctor is chosen for you, the health plan is chosen for you.

I would suggest also though, Congressman, one of the key differences is that the federal government is a much more generous partner to members of Congress in the federal employee health plan, and Congressman Ryan suggest to be the seniors in the plan that they would go into.

Their voucher system has a much lower buying power than the federal employees do right now and it in fact decreases over time, according to the Congressional Budget Office. So, rather than having the lion's share or the program paid for by the federal government, you would actually have the lion's share of the program paid for by seniors.

BUCSHON:

Well, I think that's still to be elucidated. I disagree with that premise. I don't think that's true.

SEBELIUS:

That's not my analysis. That's the Congressional Budget's analysis.

BUCSHON:

Let's move on. You talked about Medicare savings in the Affordable Care Act being against future growth. And you're aware that the Medicaid proposal to the states for block granting that what you're calling cuts is actually also savings against non-sustainable growth rate.

And is actually what you described as not cuts to Medicare but preventing further growth and that the block grants are the same thing and that it would be deceptive to say that this is actually a cut in the Medicaid program if you're calling it savings in the Medicare program under the Affordable Care Act. It's the same thing, right?

SEBELIUS:

Well, the block grant is really the administration -- the program, which if I understand it correctly, would get rid of the direction to protect vulnerable population. So states basically could pick and choose who to cover and who not to cover. The fixed...

BUCSHON:

Excuse me. They have that ability now though, don't they?

SEBELIUS:

No sir. There are some mandatory populations in Medicaid that they cannot drop.

BUCSHON:

OK. I want to move on to a different subject. NIOSH is under your jurisdiction in HHS. And under certain responsibilities to the Federal Mine Safety and Health Act of 1977, they are the technical advisor to MSHA, Mine Safety. And recently, MSHA has proposed a new rule on coal dust limitations within underground coal mines. And my dad, by the way, was a United Mine worker for 37 years.

We've asked for the background medical information from MSHA and from others. And they've said that that's being denied by Health and Human Services because of patient privacy regulations. And first of all, is that true? Is that the reason why this committee hasn't given the information?

SEBELIUS:

Congressman, I really have no -- you're saying this is a mine safety standard that...

BUCSHON:

It's coal dust mine safety standard. They're trying to cut the standard down under MSHA. And they...

SEBELIUS:

I would be delighted to get you a full and complete answer. I really have no idea.

BUCSHON:

Mr. Main also told me he would give us the medical background information on that. We haven't seen that yet. And he's saying that that's because Health and Human Services with NIOSH is denying that because it's private health information that you can't give under HIPAA regulation, but, you know, we publish medical studies everyday with groups of patients.

SEBELIUS:

As I say, Congressman, I will talk to Dr. John Howard who heads NIOSH and get you a full answer. I don't know about the mine safety regulation.

BUCSHON:

What I would appreciate is if we could get the information from NIOSH, giving all the background on the proposed rule that they submitted to MSHA that justifies this change in long- standing regulation, which in my view, as a physician, has no medical solid information that it's necessary.

And let me say, in my district in Indiana, would be devastating because many of the coal mines and others in my state would likely not be able to comply and may have to close, again, resulting in a significant amount of job loss. So I'd appreciate that information. Thank you.

KLINE:

The gentleman's time has expired. If we could take that for the record? It's a follow on question for...

SEBELIUS:

I'd be glad to. Thank you.

Miss Woolsey.

WOOLSEY:

Thank you, Mr. Chairman. I thought I'd take the opportunity, before I ask our wonderful secretary a question, to respond to the gentleman from Tennessee in his question of how the Republicans could be challenged over their proposal to privatize Medicare.

The answer is simple. And the answer is when their plan increases the tax cuts for the wealthiest Americans, when oil companies continue to get tax breaks and subsidies, when corporations, successful corporations pay absolutely no taxes, they are proposing to privatize Medicare and at the same time, asking seniors to take a blind leap of faith, that by privatizing Medicare, the private insurers will actually take care of the senior citizens in this country. And that is why there is so much

pushback to their proposal.

So, now, I want to go to my question which has to do with, you mentioned, Secretary Sebelius, a healthy development of all of our children, which of course I support 100 percent and I think part of that healthy development is ensuring that when they enter the classroom, they're well, that they're mental and physical health is being cared for. Otherwise, these kids can't learn. They can't succeed.

Well, last week, the House voted to eliminate funding for the construction of school health centers. Under the Republican bill that there are other sources of funding laying around this country that can pay for these school health centers. So, you know, you know better that I do that 8 million children lack access to any primary health care and they need this in order to get through school. So, could you expand on the value of investing in school health systems and what that means to the future of our children in our country?

SEBELIUS:

Well, Congresswoman, we're doing two things right now to expand access to coverage for children. One is to take advantage of the opportunity given by the (inaudible) authorization of 2009, to do some very extensive outreach. We think there are likely still about 5 million children who are eligible but not enrolled.

So we have a very robust outreach effort going on with school districts and health care providers using sport stars and coaches, others to try and reach the parents and enroll those kids. But there's no question, I think that and one of the most effective strategy is actually since schools are often in the hearts of neighborhoods that school-based clinic not only deals with the children-s health needs but often the family health needs of the neighborhood.

So, the Affordable Care Act designated as one of the sites for expansion of community health centers school-based clinics which was a recognition that moving in to underserved areas outreach in a very easy way for people to access health services was often very productive and certainly for parents and children to access services together is very effective.

So I think that the funding goal of expanding the school-based health clinic footprint was a wise strategy to make sure that we are reaching into many of these underserved communities and figuring out ways to have accessible health care during the time that families would most likely be able to access health care providers.

WOOLSEY:

So can you think of any pockets of funding where there's excess monies that could be without our funding these school- based health centers?

SEBELIUS:

Well, we are embarked on an expansion of the community health center footprint, unfortunately that got decreased a bit by the CR-2011 (ph) but will continue, I think, to do that because community health centers actually have been proven over and over again to be enormously effective in lower cost, high quality preventive care.

And if we want to stop paying \$.70 out of every health dollar on chronic disease, getting two conditions very early and certainly getting the kids very early. You don't learn well if you're not healthy. You can't study in school if you're not well. So, getting a productive workforce starts with having highly-educated kids and kids won't be well educated unless they're healthy.

WOOLSEY:

Thank you.

KLINE:

The gentlelady's time has expired and I was so hoping the secretary could identify one of those untouched pots of money.

SEBELIUS:

If I find it, I will tell you, Mr. Chairman.

KLINE:

I'm holding you to it.

Mr. Kelly, you're recognized.

KELLY:

Thank you, Mr. Chairman. I'd like to yield my time to my colleague, Dr. Roe.

ROE:

Thank you, gentleman, for yielding. Madam Secretary, I think we could approach an (inaudible) at the bill as you did it's a hard read (ph) and I think we could have approached getting where we wanted to be by doing exactly one of the things you just said, which if we go sign up the children, 5 million of them I think is what you said, who are currently eligible for (inaudible), the people who are currently eligible for Medicaid and the part about the bill I like a lot is to allow your adult-aged children pick your number 25, 26 or 27, you could have covered almost as many people doing those two things because you're talking about doing right now with the 2,500 paged bill and is so complex that nobody understands it.

I think I just want to make that point. I want to get into something that's near and dear to my heart, which is my fear of rationing of health care. The independent thing in advisory board is you know was not in the House version of the Affordable Care Act. It did get in the Senate version and many of my colleagues on the other side of the isle opposed this.

How do I go answer to my constituents and to patients at home that I've been saying that, "OK. We're

going to get to a certain spending level and not based on quality, we're going to make a decision about how the money is spent." How is that not going to affect rationing of care in the future when you have more services chasing fewer dollars, which is exactly the train wreck I see coming?

SEBELIUS:

Well Congressman, the way the independent payment advisory board is set up is it's 15 individuals who have to have expertise as either health care providers or health economists, experts in health who actually are forbidden by law to ration care that's part of the statutory framework, are forbidden by law...

ROE:

Let me stop you right there. Who ends up rationing is me when I can't give it in the examining room. We have 15 bureaucrats (inaudible). It's not called rationing but when you get up to a certain dollar limit and you can't spend any more money, you can't provide the service. So I'm in my examining room...

SEBELIUS:

Well, I would share your dismay about a fixed-income level and that's exactly what the House Budget proposed for Medicare. We will give you a fixed amount of money and you figure out what services you get. That is not what the independent payment advisory board is about. It's about making recommendations for strategies, for new services, for new research.

ROE:

I beg to (inaudible). In that bill...

SEBELIUS:

And that comes to Congress. Congress has the intermediary role. The Independent Payment Advisory Board's recommendations do not go into effect unless Congress chooses to allow them to go into effect.

ROE:

Well, they do go into effect unless we pick some other way not to spend...

SEBELIUS:

Unless you say no.

ROE:

Exactly. Until you say no (inaudible), unless you pick some other way not to spend the money. It is going to end up. I mean I certainly am very familiar with NICE in England (ph), the National Institute of Clinical Excellence is exactly the same type board. So I think that's what this is going to be. So you would support the IPAB when most of the Congress on the House side did not support the IPAB including my colleagues on the other side of the isle. And as a matter of fact, several of them have signed on to a bill to repeal that.

SEBELIUS:

I do very much support the notion that we would have an independent group making recommendations about cost-effective strategies. We have it now and...

ROE:

... an advisory board now.

SEBELIUS:

It is an advisory board. It would continue to be the Independent Payment Advisory Board. The recommendations would come to Congress. And again, they are not implementing medical decisions and there is no global cap that they're working under. And again, I think we're mixing...

ROE:

Well, I think we have difference of opinion there. A question I have on the mini-med plans, why were 1,100 exemptions given and what will happen to them after those exemptions expire? When they can't afford the government deciding plan, what happens then?

SEBELIUS:

Well, Dr. Roe, the laborers are a part of keeping your plan and at least the time between now and the new marketplace in 2014. Unfortunately, lots of people have some form of coverage that often is not very comprehensive and they are in a situation where currently, in 2011 and 2012 and 2013, something is better than nothing.

So the Congress directed us to take a look at the one provision of the plan that talks about getting to an annual limit that would cover comprehensive medical expenses but suggesting that if indeed a plan can't meet that annual limit without major disruption in the marketplace, between now and 2014, when there is a new exchange, a new opportunity to buy a comprehensive policy at lower cost that we should indeed look at waivers and basically 97 percent of the folks who came in the door, who gave us the documentation saying we can't get to this point because we have such frankly low coverage and modest applicability, we decided that some coverage was better than no coverage and those plans will not exist after 2014.

ROE:

I would recommend...

KLINE:

The gentleman's time...

ROE:

I yield back. I recommend you read this...

KLINE:

... has expired.

Ms. Davis, you're recognized.

DAVIS:

Thank you, Mr. Chairman and thank you, Madam Secretary for being here today and for your service as well. As you're aware, this week, the majority singled out and cut funding to create insurance exchanges where Americans could go to buy affordable coverage without discrimination.

And we know in California, and thanks to Governor Schwarzenegger in this, California is one of the first states really to get of the gate essentially to establish the exchanges. So when it comes to states like California that are already in the middle of this process, what kind of difficulties do you see as a result of cutting off the funding that this action would actually cause.

And I'm also wondering how the effort would bought funding for health exchanges across the country? Would there be some delays and what impact is it likely to have in reducing the number of uninsured Americans?

SEBELIUS:

Congresswoman, if the provision passed by the House were to be passed by the Senate and signed into law by the president, I don't think there's any question that there would be serious inability of states to move forward with creating a new marketplace, particularly for small business owners and individuals who currently are not only paying more but many of them are uninsured.

We are actually working with governors around the country to set up state-based exchanges and the resources are being used to do everything from planning to put together IT systems, so that you would have a seamless way to come into a market as an uninsured American with the goal being that every American should have available, affordable health insurance, whether you end up as a Medicaid beneficiary in a private market, in an employer market, that is the goal to have a fairly seamless system.

Defunding the exchanges would mean that we freeze the status quo where more and more Americans every year uninsured where insurance rates continue to rise at an alarming rate and families and small business owners would face either increasing cost or bankruptcy for health conditions, which they have no insurance to pay for.

DAVIS:

Is it anticipated that there would be a delay in this, perhaps a few years or that they would actually be frozen in play?

SEBELIUS:

Well, if the funding goes away, I really don't know. Take the case of California, how indeed California would put together an exchange system that would be operational by 2014. So I think it stops the process unless they find some of that money that we're looking for to fund the school-based health clinics that we haven't found yet.

If that appears, we could do this. But (inaudible) that funding stream, I think most states would just stop working on the exchange program.

DAVIS:

Thank you very much. I appreciate that. I think that we want at least in California, I know they are continuing to have these intense discussions. As you know, the earlier, in terms of the Accountable Care Organization and others and it certainly is impacting those discussions. But we're hoping that they at least will continue to have them.

I wanted to also just mention briefly just the disease prevention issues that we're all I think very concerned about and certainly singling out the National Diabetes Prevention program as well, building on evidence-based methods, giving individuals risk guidance on how to prevent type 2 diabetes.

That is eligible for funding from the Prevention and Public Health fund at HHS and so, are you saying that this issue is really going to be established as a national priority in many ways and how does that (inaudible) with the work that you're doing with this?

SEBELIUS:

Well, I don't think there's any question that the historic investment and the prevention fund is one that we see yielding significant dividends as you go forward. Again the snapshot right now is \$.70 out of every health dollar is spent on dealing with chronic disease.

And if we indeed can lower the smoking rate, if we can have a healthier population heading into their 50s and 60 by significantly making a (inaudible) and everything from diabetes to heart disease, we will have dramatic impact on not only the health cost to this country but on the health of this country.

So lower cost, better health is the goal of the prevention fund and we have some very exciting

programs underway across this country in tribes, in farm communities, in cities that are really looking at measurable ways to change behavior, to change practices, knowing that that is an enormously important step.

If we can have a healthier population invest in primary care and prevention, we won't be spending the dollars that we're currently spending.

DAVIS:

As a member of (inaudible), it's also a national security issue (inaudible) we have people coming into...

KLINE:

The gentlelady's time has expired.

DAVIS:

Thank you, Mr. Chairman.

KLINE:

Mr. Ross.

ROSS:

Thank you, Mr. Chairman.

Madam Secretary, thank you for being here. I want to address health care and jobs because we note that with the mandates that are in the Patient Protection and Affordable Health Care Act, there's going to be some burdens put on employers here, specifically in the area of service industries.

In the last 10 years, they've been the most productive types of jobs we've seen. In Florida, agriculture, retail, restaurants, hotels, intensely labor but low profit for employee.

And my concern is that we understand that there's going to be a per employee cost of about \$2,000 for health care that's going to have to be provided by these employers. These employers may not be able to either continue to keep the employments that they have and won't be able to expand.

And while I appreciate that in the Act, there are exemptions for employers with 50 or few employees. My specific question is would you consider exemptions based on a low-profit per employee?

SEBELIUS:

Well, Congressman, we're working within the framework of the law but my experience is that currently, most employers who talk to me and particularly most employers who are struggling in the marketplace find health insurance to be the best way to keep talented employees to expand their workforce to...

ROSS:

I agree but what if it becomes the cost that exceeds what the market will bear. They either going to have to release employees or scale back their time.

SEBELIUS:

Right now, they are competing against folks who often are playing on an unlevelled playing field. Often, the big employers can find health benefits and they're losing their best workers going down the street or around the corner.

I would suggest this creates a framework and the lowest income employee actually gets health with subsidies in the exchange program that they currently don't have. So it's kind of win-win.

ROSS:

You think then that the lower employees, the lower income earning employees? But if it's mandated that the employer provide the coverage and their coverage is \$2,000 per employee and they only have a margin of \$2,400 dollars per employee, that margin is going to be reduced to \$400. So these are the businesses I think that are going to be most concerned about the impact of this Act.

SEBELIUS:

Again, I'm not sure if we're talking about a large employer who currently is...

ROSS:

(inaudible) more than 50.

SEBELIUS:

If a large employer is not providing coverage and has an employee who then takes access of the coverage in the exchange, there will be an employer contribution to help pay the tax payer burden that's being picked up. A small employer would be able to participate in the exchange and have an opportunity to get lower cost coverage for employees they're not covering right now.

ROSS:

Let's talk about that exchange for a second because I appreciate the fact that as a former insurance commissioner, I mean you understand the dynamics of insurance, the market of insurance and of course that private company sell insurance for a reason to make a profit but they do so with private

capital.

That's what's going to back the risk that insure and that capital is global. They get it from certain areas. They don't consolidate the risk. And it's actuarially assessed in terms of their risk. But when the government gets in the business of insurance, they don't have that capital.

What they have is they have assessments and taxes with which to go after to satisfy any claims. And unfortunately, in the assessment of that risk, it's more politically assessed as opposed to actuarially assessed. So that being said, would you not agree then that when the government gets in the business of insurance, that what they're putting at risk are taxpayer dollars and assessments as opposed to private capital that spreads globally?

SEBELIUS:

Well, I would say that there certainly is more tax payer dollar involved in the government based plans but I would also suggest that private insurers right now participate actively in Medicare Advantage programs. Most states run their (inaudible) programs through the private market. They are Medicaid beneficiaries, so there is not a line drawn between government plans and the private market.

ROSS:

Well, there is. There is though and I think that's something that we have to talk about. If we're going to talk about health insurance, because our president said at the (inaudible) of his lobbying on this bill that we had a health insurance crisis. And as you know, each state, under the McCarran-Ferguson Act, regulates their insurance market.

But we've got fewer insurance companies in the State of Florida because of mandates in Florida, fewer in Alabama but yet we have over 1,200 insurance companies that want to sell health insurance throughout this country. Would you not agree then that for consumers, for a market that wants to be based on capital and not taxpayer dollar supporting it, we should open up the barriers and allow for the interstate sale of health insurance?

SEBELIUS:

Well, Congressman, as you know, companies can now sell in any state that they want. They have to be licensed by the state and they actually have to follow the state laws but...

ROSS:

But they have different mandates. In other words you've got 51 mandates in Florida, you may have three in Alabama, you may have so many more in Pennsylvania...

SEBELIUS:

The elected legislators in Florida passed laws that the governor signed...

KLINE:

The gentleman's time has expired.

ROSS:

Thank you.

KLINE:

Mr. Scott.

SCOTT:

Thank you, Mr. Chairman.

Madam Secretary, just a quick (inaudible) question. Is it possible for any sponsors of programs run in your department private organizations to get grants to run (ph) programs, to discriminate based on religion that is to say you would have been a good applicant for this job but we don't hire people of your religion? Is that possible?

SEBELIUS:

To my knowledge, that would violate the civil rights umbrella that we operate under, Congressman.

SCOTT:

So that just says faith-based organization, we're running a program and said we don't hire Catholics, Jews or Muslims, you wouldn't think they could get funded under your administration do you?

SEBELIUS:

To my knowledge, no.

SCOTT:

Thank you. Under the essential benefit definition under the ACA, it's my understanding that the Institute of Medicine is currently working on recommendations in terms of children the EPSDT program under Medicaid is considered a good standard for care for children. Would it be a recommendation that that be the essential benefit package for children under ACA?

SEBELIUS:

Well, Congressman, the way that actually the essential benefit portion of the discussion is framed in the ACA. There're multiple steps. The Department of Labor has just given us the results of a survey that they did on private market plans, the typical benefits in a private market plan looking at large employers and small employers. So that's a step mandated by the law.

What the Institute of Medicine is doing is sort of step two which is looking at the process for putting together an essential benefit package and how often that criteria would be updated.

Step three is really for HHS (inaudible) to do extensive listening and outreach to everybody from provider groups to disease groups, to patient advocates in terms of getting input on what an essential benefit package would look like and then a rule will be promulgated. So IOM is actually really more on the process side. They're not doing the health benefit side.

SCOTT:

The EPSDT package of benefits, do you consider that something worth recommending?

SEBELIUS:

Well, I think it certainly sets the standard for an effective package for children and currently, the Affordable Care Act would say that the preventive care that is offered needs to be part of all insurance policies going forward if it's recommended as part of the prevention protocol.

SCOTT:

The GOP budget makes certain spending cuts, co-grants, education, transportation, like high-speed rail, law enforcement, food and drug administration, a list of cuts that totaled about \$800 billion, which they totally offset with extending tax cuts with that portion of your income over \$250,000 dollars. So that's a complete wash. All of their net savings come from Medicare and Medicaid cuts in those programs. Are you familiar with their little voucher program?

SEBELIUS:

With?

SCOTT:

The voucher program and the...

SEBELIUS:

The Medicare.

SCOTT:

... and the Medicare proposal?

SEBELIUS:

Yes sir.

SCOTT:

Does it provide any limit on what the private industry can charge?

SEBELIUS:

Not to my knowledge. I haven't seen the underlying details. Maybe they exist but I haven't at least seen them. I've seen the outlines (inaudible).

SCOTT:

(inaudible) guaranteed issue if you get one of these vouchers that you can actually buy some insurance somewhere?

SEBELIUS:

There is, I think, a limitation on, a ban on eliminating people because of pre-existing conditions but whether or not the dollar amount itself would allow you to buy a plan, I don't know.

SCOTT:

If you can't afford it, are there any subsidies to help you buy the insurance?

SEBELIUS:

There are, if I understand it correctly, additional resources available to the lowest income. So there is some sliding scale that would increase the buying power of the voucher depending on income.

SCOTT:

And as I understand it, when it starts off, the senior citizens will be paying about \$6,000 more of their income towards this policy and after about 10 more years, it gets up to about \$12,000, which would be about half the average Social Security check, is that right?

SEBELIUS:

Yes, I think there's a dramatic shift of cost on to seniors.

SCOTT:

Thank you, Mr. Chairman.

KLINE:

I thank the gentleman.

Mr. Gowdy.

GOWDY:

Thank you, Mr. Chairman. Madam Secretary, do you believe the commerce clause has sufficient elasticity to allow Congress to mandate individuals purchase health insurance?

SEBELIUS:

I try not to practice law without a license but I have listened closely to our legal team and I think they believe strongly that the bill stands on solid constitutional grounds.

GOWDY:

You would have to believe that or wouldn't be able to support the president's health care reform, right?

SEBELIUS:

That's correct.

GOWDY:

And because you believe that, you also would necessarily have to believe that Congress can also pass medical malpractice reform because we would use that same commerce clause. And I found it instructive that this administration has not proposed any medical malpractice reform. So perhaps we can take this opportunity and identify what medical malpractice reform initiatives you would support.

SEBELIUS:

Actually, Congressman, the last statement is not accurate. The president asked me during the course of the health care debate to actually use the powers that had been with HHS for a period of time, to put in place some targeted programs around the country which are currently...

GOWDY:

I'm not talking about the targeted programs, Madam Secretary.

SEBELIUS:

They are looking at what kind of medical malpractice actually has the following criteria. (inaudible) patient safety lowers liability cost...

GOWDY:

Has this administration proposed specific medical malpractice reform initiatives?

SEBELIUS:

I've just explained to you what's underway right now. They are actually in place.

GOWDY:

Give me one. Give me a specific, joint (ph) several liability. Have you proposed reforming that?

SEBELIUS:

Are you saying have we proposed the law to change and preempt state law?

GOWDY:

Have you (inaudible) cause of medical malpractice reforms...

SEBELIUS:

We actually right now have across the country, health care systems and court systems putting in place malpractice reforms that meet criteria to see and measure what exactly works because the data is pretty inconclusive whether or not you can increase patient safety and lower liability rates by a variety of strategies.

So those are in place right now. They were put in place by our budget with our authority that had actually never been used before by anybody but President Obama.

GOWDY:

Do you support reforming joint and several liability?

SEBELIUS:

Do I support preempting state law by Congress? No sir.

GOWDY:

Well, Ma'am, there lies the issue, right, because why would that be a preempting of state law in any greater degree than any other federal initiative. You think if we were to reform joint and several liability that that would preempt state law?

SEBELIUS:

I think stated a time they have taken on that issue and dealt with it. Yes, sir.

GOWDY:

What about a different standard of care for emergency medicine? Would you support...

SEBELIUS:

I have no idea what is the different standard of care. What does...

GOWDY:

There's not. So if a physician is treating someone at a ballgame or at a church and doesn't know the patient history, there's no different standard by which their practice would be judged than if they had a 20-year long history with that particular patient. So my question is would you support a different standard?

SEBELIUS:

I'd be delighted to look at any proposal. I think it's impossible to answer a question when I haven't seen the specifics of what's being talked about and how it would impact but I'd be happy to take a look at it.

GOWDY:

I read your comments about the debt and I've read the president's comments about the debt. And I assumed you would agree that because you've said that our debt is stifling.

So my question is, given the fact that we agree on that, why was there no proposal for entitlement reform in this administration's initial budget?

SEBELIUS:

Well, Congressman, I would suggest that the Affordable Care Act had a significant step toward entitlement reform with the \$500 billion reduction in growth rate of Medicare. That was a big step forward. That was not supported by many in this Congress but it was the President's first step.

I would also suggest that the IPAP proposal, which is part of the Affordable Care Act is also another big step in terms of entitlement reform that actually doesn't potentially cause harm to our seniors, but makes us make more strategic decisions about cost effectiveness of proposals.

We are currently working on proposals around dual eligible's, which is the most significant cost driver in Medicaid and have a proposal underway in our innovation center where 15 states are going to be participating to see if we can really find health strategies that look at that highest cost population. So there are significant steps underway on the entitlement reform.

GOWDY:

Let me excuse us because the light just went off. If the president's initial health care reform bill was sufficient, why did he then come out with a second budget after Paul Ryan took on entitlement reform, why did you come out with a second budget that dealt with it?

KLINE:

The gentleman's time has expired.

Miss Hirono.

HIRONO:

Thank you, Mr. Chairman, and Madam Secretary. I just would like to make a comment regarding medical malpractice reform. I'd like to see the evidence that connects malpractice reform with lowering of medical malpractice insurance. There's never been (inaudible) that. I don't think it has been shown and therefore, you know, I'd like to see that evidence because states all across the country have enacted medical malpractice reform and the doctors are still paying huge premiums for medical malpractice.

I think in both education and health care, early intervention and prevention are the keys because we save money in the long run and that's why we should be supporting programs such as school-based health centers and Head Start and quality early education. I've been a major proponent of quality early education.

And Madam Secretary, I understand that you had responded to a question regarding the third round, a race to the top where you're department and the department of education will be working together to, I hope come up with an early learning competition that is kind of like the early learning challenge fund.

And so I'm glad to hear that. I did send a letter to both you and our Education Secretary, Arne

Duncan, to that point and I await your response.

I want to go on to the Medicare changes that the Republicans would like to propose. During the two weeks that I was in Hawaii, I met with hundreds of seniors and they are very concerned about what the Republicans have in mind for Medicare. For one thing, they're totally astounded that they would have to wait until age 67 before they qualify for Medicare.

And I know that they're thinking about when they were 65 and finally got on Medicare health insurance, and I know that they were thinking, what if we had to go two years to 67 without any insurance. So then the next area that they're really concerned about is even if they're currently on Medicare, they care about those who are under 55, who are going to be in this new plan as the Republicans would like to enact.

So this voucher system, you responded to some questions about the voucher system and I'm not clear exactly how that is supposed to work. You're a 67-year-old senior, you get a voucher and what, what is supposed to happen? What are you supposed to do to get health insurance?

SEBELIUS:

Congresswoman, I don't pretend to have all the details but my understanding is it would essentially operate as a subsidy to purchase private insurance coverage. There would be some rules around, as I said, a limitation on pre-existing conditions so you can be locked out on the marketplace.

I don't know that there's any framework of what you could purchase with that coverage. So I assume that companies would put together packages, somebody would make a choice about whether that package would be sufficient or I really don't know all the details about how it works.

HIRONO:

Thank you, because I'm wondering what kind of packages the private insurance company will put together for 67-year-old and older with all these preexisting conditions. Even if they cannot deny insurance because of preexisting condition.

I'm wondering whether all these private insurance companies will stand in line to put together these kinds of programs for 67 years old. And in fact, when I asked that question of the hundreds of seniors that I talked to, they couldn't even -- they were just -- I know they were very scared as to how this was supposed to happen.

So would you share that kind of concern that I have as to whether the private insurance industry can be counted on to come up with all these different plans that our seniors could avail themselves off?

SEBELIUS:

Well, we currently have some model of the private market in Medicare space with Medicare Advantage programs. That has been in operation for over a decade. On average, they are more costly than Fee-for-Service Medicare with no perceptible health improvements whatsoever after 10 years.

We know that the companies have done somewhat effective jobs of doing a bit of cherry-picking in the marketplace. And I think that that's really how you make a profit in health insurance is that you hopefully get a population that's less sick and more sick.

And what I think is a great concern is that the amount of money identified as the fixed benefit nowhere nearly matches the potential cost of the services to the average Medicare beneficiary right now, much less down the road and that buying power diminishes over time.

HIRONO:

And I think the seniors across our country are understanding that with regard to the Ryan's Budget. Thank you.

KLINE:

The gentlelady's time has expired.

Mr. Barletta?

BARLETTA:

Thank you, Mr. Chairman.

Madam Secretary, as you know the PPACA has made significant changes to the laws governing insurance markets and employer sponsored health care. Many of which have the effect of increasing cost for employers, workers and their families in an effort to pay for the new subsidy entitlement program, PPACA reduces Medicare expenditures by more than \$500 billion.

And imposes hundreds of billions of dollars in new taxes and penalties, which will likely raise the cost of coverage and increase the financial pressures on employers struggling to grow their businesses and create jobs. With small business home health care providers, this is a huge burden.

I have specifically heard from my constituents about the 2.3 percent excise tax on manufacturers and importers of certain medical devices. How can you justify this tax, especially for small businesses, homecare providers who work in rural areas?

SEBELIUS:

Well, Congressman, I think that one of the features of the Affordable Care Act, which is different frankly from Prescription Drug Act that was passed in a prior administration is that it's paid for. And it does not add to the deficit. In fact, the Congressional Budget Office has estimated that about \$230 billion in the first decade and over a trillion dollars in the second decade will be decreased from the deficit.

So, there are pay fors (ph) in the bill. I think the tradeoff that you're talking about with a tax on home

health manufacturers is that they are also anticipating additional customers along the way. So there is some additional revenue that will be generated and the return is that they will have access to a far more significant market who will have actually the ability to pay for home health services where they don't right now.

BARLETTA:

Moving on to another question. In response to the questions I've received from small business pharmacist in North Eastern Pennsylvania, would you be able to address the rapid refill of prescription medicine?

More specifically, many in my community are concerned that prescriptions are being offered in 90 day increments by certain large scale stores, even though their primary care physician may modify the prescription prior to its expiration. Is this new process allowed by the Department of Health and Human Services as a result of PPACA?

SEBELIUS:

I can tell you that there's no new process about prescription refills that's part of the Affordable Care Act. I don't know what's causing what you're talking about, but I'd be happy to go talk to our folks and see if they have heard about it or know about it but there is absolutely nothing that's been put into effect in the year that has any impact on prescription drug refills.

BARLETTA:

As a former mayor of a city in North Eastern Pennsylvania, Hazelton, I witnessed firsthand the benefits of the human service programs operated by HHS. I'm specifically familiar with and interested in the Community Services Block Grant program. The President's 2012 budget request includes a \$388 million cut to the Community Services Block Grant program, which as you know has geared toward anti-poverty activities.

Over the last 10 years, a number of independent studies including those conducted by GAO have questioned the program's effectiveness in combating poverty in local communities.

In my community, the Commission on Economic Opportunity, an organization committed to combating the local poverty. They used the Community Services Block Grant funding to help promote self-sufficiency among low income populations in Luzerne County.

And in February, I had the privilege of meeting with the officials of this organization and I toured their after-school program that ensures children get healthy meals throughout the year. In fact, this organization's food bank, which also assist the elderly population in Luzerne County has provided over 4 million pounds of food to 160 agencies over the past year.

Now I've seen the good of this program and others like it, I am supportive in finding ways to make the CSBG program even stronger. What changes do you think the committee should make to the Community Services Block Grant program to make it more effective and when was the last time this program was evaluated?

SEBELIUS:

Congressman, first of all, let me say, I would look forward to working with you to do just that. I think that there's no question at all that the reduction in funding that's being proposed is not one that would have been proposed if the budget times were better.

Let me start there. I also think that it's been our experience that the funds administered through the state and to a variety of community action agency. Some are very confident and effective. Others have been less effective and we are currently in a process of reviewing, knowing that we're likely to have diminished resources, what are the kinds of criteria to put in place that would actually drive the best practices around the country, because I would say that program impact has been really mixed, but we would look forward to working with you around what that strategy looks like.

BARLETTA:

Thank you.

KLINE:

The gentleman's time has expired.

Mr. Tierney.

TIERNEY:

Thank you, Mr. Chairman.

Madam Secretary, thank you for being here today. Let me just start with couple of very brief questions about low-income home fuel assistance. Can you give me an idea of when that money is going to be released to the states, because we have reports of people fearing the lives of their utilities if that money doesn't get released to the states so that they can distribute it?

SEBELIUS:

I'm trying to get my experts back here to give me a...

TIERNEY:

Well, if you can't give me that answer, if you can't give it to me right now, if you could get that to us when you can.

SEBELIUS:

We'll get it to you, sure, and what we've tried to do up until this moment, I can tell you is put the

money out the door as soon as we have the authorization. So I can get you the precise date. We'll try to push the rest of the F.Y. '11 money out.

TIERNEY:

I appreciate that. The president's proposal for the fiscal year 2012, he proposed a 40 percent cut in those funds, premised on the idea that the cost were going to be similar around, somewhat lower in the future. Now, the cost had backed up to what they were in 2008 for oil, they're increasing for gas. Are you going to revisit that decision?

SEBELIUS:

Well, Congressman, as you know, the budget has been proposed. We would look forward to working with you. I know it's a vital program. It was a snapshot that looked like we were in times that could return to the historic level, but I think we need to look at the challenges and that impact on particularly the low-income families who rely on it.

TIERNEY:

We would appreciate that, thank you. We'll work with you on that as well. Just a quick comment on the medical malpractice, we did quite a bit of looking at that. Are you aware of any study at all that indicates that even if all the medical malpractice reforms proposed went into effect, that it would do anything more than say the miniscule fraction of the National Health Care cost?

SEBELIUS:

Well, I think right now, malpractice premiums are far less than 1 percent of any health care cost. And unfortunately, the data is very erratic. States that have put in place every kind of (inaudible) reform possible and states that have no (inaudible) reform possible seemed to have about the same malpractice rate.

So there doesn't seem to be a corollary impact between the legal framework and what doctors are paying. It's difficult to assess and measure what defensive medicine costs. It's also, I think very difficult to measure what a lack of patient safety cost and those, you know, we talked about errors that occur in the medical system right now, which kill about a hundred thousand people a year. So, I think that balance is very critical.

TIERNEY:

And it's a state regulated insurance industry, is that correct?

SEBELIUS:

That's correct, sir.

TIERNEY:

Lastly, I do see reports, however that draw a correlation between the return on investment from reserved funds by insurance companies and the increase in premiums. I think that will be a more appropriate place to look for some correlations. Is that correct?

SEBELIUS:

Well, I think the malpractice market has been very lucrative.

TIERNEY:

Yes indeed. Community health centers, in H.R. 1, the original proposal for continuing resolution, there was a proposal to substantially cut the funding for those centers. If it would have closed, about 127 centers. If it would have been passed, it would have cut off about 11 million participants.

It would have caused thousands of people to lose their jobs. In the end, it was less severe reduction in that, but can you talk to us just for a second about the value of community health centers what used to be a bipartisan priority. I remember having a word with President Bush on this as well, how important it is or isn't to our system and what attention we should be giving to those centers?

SEBELIUS:

I don't think there's any question that the current community health center footprint is an enormously important infrastructure for low-cost, high-quality delivery of health care in the most underserved rural and urban areas. The training of docs in community health centers is a terrific training ground.

And over and over again, they are proven to be enormously effective. The trajectory that this administration proposed was actually moving from the opportunity from 20 million American served by community health centers to 40 million American. Starting with the investment in the recovery act and moving on through the Affordable Care Act.

That's taken a little bit of a bump in the road but we still feel that having an expansion of community health centers and matching them to the most underserved area is that most effective, most efficient, most cost-effective way of getting high-quality health services to people who now have limited access to doctors.

TIERNEY:

Thank you. Let me just close with the notion that the Medicare and the Affordable Care Act reduce money. I think we've made the point (inaudible) want to reiterate it. It would slow the growth of cost and I note that in the Republican proposal, they don't change that fact. They like the savings of those costs and I understand that that was in fact addressing an entitlement by slowing the growth and costs without reducing the number of defined benefits. Is that correct?

SEBELIUS:

Well that's absolutely correct. In fact, the language in the bill as you know re-emphasizes the fact that

no defined benefit can be tampered with. So, in fact, the Affordable Care Act increased the benefits. So seniors now will have the doughnut hole closed over time, not falling to the gap in drug coverage.

We'll have an annual wellness benefit. We'll have preventive care without co-pays. So there are some significant enhancements as part of the guaranteed Medicare benefits along with the reduction in the cost overtime.

TIERNEY:

Thank you.

KLINE:

The gentleman's time has expired.

Madam Secretary, we have two final questioners and we'd like to allow both of them to have an opportunity.

So Mr. Rokita, you're recognized.

ROKITA:

Thank you, Mr. Chairman.

And thank you, Madam Secretary. I am one of the last questionnaires; so hopefully, we'll be able to respect your time. I appreciate your being here. With regard to this medical malpractice that has popped up here lately, of course you understand that at least for many Americans, many of us that I represent, it's not the premium that the doctors pay that's the concern. It's the defensive medicine cost.

And you indicated that it might be a hard (inaudible) determine. I don't know if I agree with that. I think we've been able to determine in this country a lot of other things. And my doctor colleagues, including the two that sat on either side of me on this committee, when I asked them before they left, they said, it could be anywhere between a \$100 billion and \$500 billion a year in defensive medicine cost.

And they do this every day as specialists, at least. So, I wanted to let you know about the member of Budget Committee, in case you're asked these things again. I need you to know that the plan, you said that you saw some outline of the budget but (inaudible) show you the details.

It's not the voucher. It doesn't go to the person. It goes to the insurance companies who would want to participate. And on our federal plan, as Dr. Bucshon was explaining, there are at least nine or so different kinds of plans, depending on what part of life we're in that we can choose from and to the extent that Congress is a microcosm of the people generally. I really don't understand why that couldn't work.

SEBELIUS:

Well, part of it is the federal government is paying 70 percent of the cost of your health care right now. And assuming that you're in the federal employee benefit package, this plan is significantly less generous for a more, I would say, likely to be sick population, more difficult conditions, and the growing, it doesn't rise with the cost of...

ROKITA:

You know, I think that wasn't in your outline, because if you look at our plan, we are calling for a needs (ph) test and we are calling for a risk test. Those of us who are sicker will get more of it. Those of us who need less of it because of our stage in life or state in life would get less of a subsidy.

SEBELIUS:

But again, according to the Congressional Budget office, it's significantly less buying power than Medicare provides right now for seniors. And it actually, the buying power decreases overtime, again, according to the Congressional Budget office. And they're saying 10 to 15 years out, 70 percent of the cost of health care would be borne by the senior themselves, not the...

ROKITA:

But you come from state government. Like I do, I was part of the executive branch of the Indiana government. And so, you know, I come to this place not believing everything CBO says, especially how they're chartered. They are only allowed to look at exactly what's put in front of them. And so we both know that...

SEBELIUS:

If I understand that specs given to them by the House Republicans, by Congressman Ryan, those were the only specs.

ROKITA:

Except (inaudible) in a previous act if they're chartered by. And we can argue around all that long (inaudible) we both know for that we have a program that works for the Congress and we both know people clamor and talk about how much, how good we have it here in the Congress, and to see us argue now against that for the rest of the American people, (inaudible) let me get on with (inaudible).

SEBELIUS:

Well, again, there's no evidence at all that Medicare Advantage, which operates through private market strategy gives seniors choices is either a more cost-effective or more health- effective. For seniors, in fact, the cost is significantly higher in the health benefits or lower.

ROKITA:

(inaudible) as Dr. Bucshon was explaining, you weren't seemed (ph) to understand the details. Here are some of the details. Joe Main is the assistant secretary for Mine Safety, not under your jurisdiction of course. But he apparently used something from the (inaudible) data from (inaudible) to go after the coal dust (inaudible) to propose some things.

Now he, on March 28, wrote your office and said, "Please release the status, not minor release, but please, get this to this committee and the stakeholders involved so that we can participate better in this rule making." And so, what I want to ask you on the record, I think you said it with Dr. Bucshon, you'd be helpful in trying to get that, right?

SEBELIUS:

Absolutely. I don't know about that issue.

ROKITA:

Understood, but again, sharing your executive experience, I could tell you, you got people behind you that you can easily turn around to and say, what date can we get Congressman Rokita some answers on this. Can you tell me how...

SEBELIUS:

I can't give you a date certain until I know what it is that we're looking for but I can guarantee you, all of us heard the question four or five times. We understand there's a letter and I'll try to get...

ROKITA:

But you can get that data as to when you'll give me the answer.

SEBELIUS:

Sir, I really don't know what it is that we are being asked to produce. I will get you an answer very quickly.

ROKITA:

Yeah, just an answer about when it would come. That simple. So, if it was me in your seat, I'd say, you know, 24 hours or so. But give me whatever answer you can, just tell me when you'll me that answer and when this stuff might come.

SEBELIUS:

I don't know what it is that you're looking for so I can't possibly give you, I'll give you an answer about when it will come, you know, within a couple of days once I can talk to Dr. Howard.

ROKITA:

That's all I'm looking for. I appreciate it.

KLINE:

The gentleman's time has expired.

Mr. Hinojosa, you're recognized.

HINOJOSA:

Thank you, Mr. Chairman.

Secretary Sebelius, thank you for joining us today to discuss your priorities and to respond to the Ryan Budget proposal put forward by the Republican party. I'm troubled by the Republican plan to end Medicare as we know it. For my constituents in South Texas, the Republican plan would be disastrous.

It would force seniors into the private sector for insurance and it would force them spend more and more of their limited income on health care. In regards to our nation's youngest (ph), just yesterday, I sat down in my office with a pediatric anesthesiologist cuddling to treat some of my districts most impoverished and vulnerable youth.

Many of which are Medicaid beneficiaries. The Republican plan slashing Medicaid is not the answer that providers or children are looking for because it would unjustifiably hurt access to quality care. I wish to ask you questions. As the former insurance commissioner and governor of Kansas, you understand the heavy burden of health care cost on seniors and families with children in poverty.

What is the Obama administration doing to help bear that burden and what new strategies are being pursued for helping our most vulnerable populations?

SEBELIUS:

Well, Congressman, I think the president shares your concern about the access to care for the most vulnerable Americans and that's why I think he has stated an opposition to the Block Grant idea with a fixed amount of money available, knowing that you can't predict recessions, you can't predict disasters and you certainly can't predict how many people are needing to access program at a difficult time as we've just seen in this country.

The same would be true for Medicare, to change from what is a guaranteed benefit program to a fixed-income situation I think could provide an enormous cost shift unto seniors at a time where they could least afford it and make it very, very difficult to access life saving care.

HINOJOSA:

With respect to Head Start, HHS is in the process of implementing the new performance standards, seeing more parent and family engagements in our early education services is very important to me. Will you please tell us how these performance standards will strengthen the Head Start program?

SEBELIUS:

Well, Congressman, we're taking the report on program integrity very seriously and we think it's important that the Head Start grantees follow the law, follow the guidelines. In addition, we're working closely with our education partners to look at the range of skills that children need to be school ready and making sure that in addition to social development that there is a curriculum development as part of the Head Start program.

And certainly the parental involvement piece, which has been always a hallmark of Head Start is something that is going to be strengthened and very critical moving forward.

HINOJOSA:

Mr. Chairman, thank you for letting me ask those questions. I yield back.

KLINE:

I thank the gentleman. Timing is near perfect. I'd like to thank the secretary for being with us, spending the time with us today and putting up with the interruptions from the votes.

I'd like to recognize Mr. Miller for any closing comments you might have

MILLER:

Thank you very much.

I want to thank you, Secretary, very much for being here. And I just want to say, after listening to your explanations and your defense of the Accountable Care Act, when I see the excitement and the response across the medical community and the employer community to this legislation and to the initiatives that you've started to roll out, it's really very, very encouraging.

After the Accountable Care Act passed the Congress, President Obama called me and said that I should be very proud as being one of the chairs of the committees for major jurisdiction on this legislation. I obviously told them I was very proud

But listening to your defense and your explanations here and your initiatives, on behalf of the law and the government, I'm even more proud in that moment when we passed this legislation because this is the kind of implementation that we we're hoping.

And to see now, hundreds of thousands of employees being offered insurance by small businesses because of the tax credit for the first time being reported all over the country is really very exciting for

those individuals and their families. So thank you very much for your appearance here before the committee.

KLINE:

I thank the gentlemen. It's always interesting here and I must always talk to different businessmen and women and different care providers. I'm not yet seeing that excitement on their part and I don't share that excitement with them but I again very much appreciate your time and your testimony here today. There being no further business, the committee is adjourned.

CQ Transcriptions, May 5, 2011

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